CHAPTER 400

MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

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400 CHAPTER OVERVIEW

AHCCCS covers a comprehensive package of services for women, newborns and children that includes:

1. Maternity care services

2. Family planning services

3. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for eligible children under 21 years of age.

While these service programs are closely intertwined, this Chapter discusses the policy and procedural guidelines for each of them separately. The discussion for each component includes: a service description, criteria for coverage, services with special policies, and procedural guidelines for Contractors and/or fee-for-service providers.

Contractors must promote improvement in the quality of care provided to enrolled members receiving maternity care, family planning, EPSDT and KidsCare services. Refer to Chapter 900 for quality management and performance improvement requirements. These requirements apply to all AHCCCS covered services, including maternal and child health.

Refer to Chapter 500 for a complete discussion of care coordination and requirements.

Refer to Chapter 600 for a complete discussion of provider and network requirements.

Refer to Appendix I, Body Mass Index Charts, for a group of weight charts for both children and adults.

• REFERENCES

1. Title 42, Code of Federal Regulations (42 CFR) Part 441, Subpart B [EPSDT]

2. 42 CFR 441.306 [Maternal and Child Health]

3. Social Security Act, Section 1905(R) [EPSDT}

4. Social Security Act, Title V, Parts 1 and 4 [Maternal and Child Health]

5. Arizona Revised Statutes (A.R.S.) 36-2907 [Covered health and medical services]

6. A.R.S. Title 36, Chapter 2, Article 3 [Children's Rehabilitative Services]

7. A.R.S. Title 36, Chapter 29, Article 4 [KidsCare]

8. Arizona Administrative Code (A.A.C.) Title 9, Chapter 22, Article 2 [EPSDT]

9. A.A.C., Title 9, Chapter 31 [KidsCare]

10. A.A.C., Title 9, Chapter 14, Article 5 [Tests for endocrine disorders, metabolic disorders and hemoglobinopathies]

11. Arizona State Laws of 2005, Chapter 172 [Report of blood test; Newborn Screening Program; Fee; Definitions]

12. AHCCCS Acute Care Contract, Section D

13. AHCCCS ALTCS Contract, Section D

14. AHCCCS CMDP Contract, Section D

15. AHCCCS CRS Contract, Section D

16. AHCCCS (Department of Health Care Management) Contractor Operations Manual

17. Arizona Hospitals' Universal Newborn Hearing Screening, 2001 Guidelines, http://www.azdhs.gov/phs/owch/newbrnscrn.htm

18. Joint Committee on Infant Hearing Year 2000 Position Statement, http://www.cdc.gov/ncbddd/ehdi/documents/jcihyr2000.pdf

19. Centers for Medicare and Medicaid Services (CMS), Guide to Children's Dental Care in Medicaid, http://cms.hhs.gov/medicaid/epsdt/dentalguide.pdf

EXHIBIT 400-1

MATERNAL AND CHILD HEALTH REPORTING REQUIREMENTS (DUE TO AHCCCS/DHCM) *

EXHIBIT 400-1

MATERNAL AND CHILD HEALTH REPORTING REQUIREMENTS
(DUE TO AHCCCS/DHCM) *

REPORT	DUE DATE*	REPORTS DIRECTED TO:
Monthly Pregnancy Termination Report (Exhibit 410-2)	Monthly no later than 30 days following the end of the month.	Division Of Health Care Management - Clinical Quality Management Unit (DHCM/CQM)
Maternity Care and Family Planning Services Plan	Annually, by December 15.	DHCM/CQM
AIDS/HIV Pregnant Women Report (Exhibit 410-4)	Semiannually, no later than 30 days after the end of the 2nd and 4th quarters of each contract year. (April 30 and October 30)	DHCM/CQM
Comprehensive EPSDT Plan (Including Oral Health)	Annually, by December 15.	DHCM/CQM
EPSDT Progress Report including Oral Health.	Quarterly, within 15 days of the end of each quarter.	DHCM/CQM
ADDITIONAL REPORTING (AS NEEDED)		
Sterilization of SOBRA members	At the time of newborn reporting or at any time during the 24 month coverage of family planning extension services	AHCCCS Division of Member Services
Stillbirth Supplement Request (Exhibit 410-5)	Within six months of delivery date	DHCM/CQM

Revised: 4/2004, 2/2001

* An extension of time to complete a report may be requested by contacting the Administrator of the Clinical Quality Management Unit in DHCM.

410 MATERNITY CARE SERVICES

Description. AHCCCS covers a full continuum of maternity care services for all eligible, enrolled members of childbearing age.

Amount, Duration and Scope. Maternity care services include, but are not limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary prenatal services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and delivery services, and postpartum care. In addition, related services such as outreach, education, and family planning services (Policy 420) are provided whenever appropriate, based on the member's current eligibility and enrollment.-

All maternity care services must be delivered by qualified physicians and non-physician practitioners and must be provided in compliance with the most current American College of Obstetricians and Gynecologists standards for obstetric and gynecologic services. Prenatal care, labor/delivery and postpartum care services may be provided by licensed midwives within their scope of practice.

A. MATERNITY CARE SERVICE DEFINITIONS

1. High-risk pregnancy is a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tool.

2. Licensed Midwife means an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to Arizona Revised Statutes (A.R.S.) Title 36, Chapter 6, Article 7 and Arizona Administrative Code Title 9, Chapter 16. (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board.)

3. Maternity care includes medically necessary preconception counseling, identification of pregnancy, prenatal care, labor and delivery services and postpartum care.

4. Maternity care coordination consists of the following maternity care related activities: determining the member's medical or medical/social needs through a risk assessment; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers; monitoring to ensure the services are received and revising the plan of care as appropriate.

5. Practitioner refers to certified nurse practitioners in midwifery, physician's assistants and other nurse practitioners. Physician's assistants and nurse practitioners are defined in A.R.S. Title 32, Chapters 25 and 15 respectively.

6. Postpartum care is the health care provided for a period of up to 60 days post delivery. Family planning services, as addressed in Policy 420 of this Chapter, are included if provided by a physician or practitioner.

7. Preconception counseling focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed) as well as regular health care. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.

8. Prenatal care is the health care provided during pregnancy and is composed of three major components:

   a. Early and continuous risk assessment

   b. Health promotion; and

   c. Medical monitoring, intervention and follow-up.

B. CONTRACTOR REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

Contractors must establish and operate a maternity care program with program goals directed at achieving good birth outcomes. The minimum requirements of the maternity care program are:

1. Appropriately qualified personnel in sufficient numbers to carry out the components of the maternity care program for eligible enrolled members.

2. Outreach activities to identify currently enrolled pregnant women and enter them into prenatal care as soon as possible. The program must include protocols for service providers to notify the Contractor promptly when members have tested positive for pregnancy. In addition, Contractors must have an ongoing process to monitor and evaluate the effectiveness of outreach activities.

3. Written protocols to inform all enrolled AHCCCS pregnant women and maternity care providers of voluntary prenatal HIV testing, and of the availability of counseling if the test is positive.

    a. Each Contractor must include information in the member newsletter, maternity packets, provider instructions, and/or the member handbook at least annually to encourage pregnant women to be tested and provide instructions on where testing is available.

    b. Semiannually, each Contractor must report to AHCCCS the number of pregnant women who have been identified as HIV positive. This report (Exhibit 410-4) is due no later than 30 days after the end of the second and fourth quarters of the contract year.

4. Designation of a maternity care provider for each enrolled pregnant woman for the duration of her pregnancy and postpartum care. Such designations must be consistent with AHCCCS Acute Care and Long Term Care contract requirements, allowing freedom of choice while not compromising the continuity of care.

5. Provision of information to newly assigned pregnant members, and those currently under the care of a non-network provider, regarding the opportunity to change Contractors to ensure continuity of prenatal care.

6. Written intake procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool covering psychosocial, nutritional, medical and educational factors (available from the American College of Obstetricians and Gynecologists [ACOG] or the Mutual Insurance Company of Arizona [MICA]).

7. Mandatory availability of maternity care coordination services for enrolled pregnant women who are determined to be medically/socially at risk or high risk by the maternity care provider or the Contractor.

8. Demonstration of an established mechanism for assuring that:

    a. Network physicians and practitioners adhere to the ACOG standards of care including the use of a standardized medical risk assessment tool and ongoing risk assessment

    b. Network physicians and practitioners are educated in the application process for Baby Arizona. For additional information, please call the Arizona Department of Health Services Hotline at 1-800-833-4642.

    c. Licensed midwives, if included in the Contractor's provider network, adhere to standards of care specified within their scope of practice and use the AHCCCS standardized risk assessment form (Exhibit 410-3) in accordance with requirements specified in the Licensed Midwife Services section of this policy

    d. Maternity care providers educate members about healthy behaviors during pregnancy including proper nutrition, smoking cessation, the physiology of pregnancy, the process of labor and delivery, breast-feeding and other infant care information

    e. Members are referred for support services to the Women, Infants and Children Supplemental Nutrition Program, as well as other community-based resources to support healthy pregnancy outcomes. Members must be notified that in the event they lose eligibility, they may contact the Arizona Department of Health Services Hot Line for referrals to low or no-cost services.

    f. Maternity care providers maintain a complete medical record documenting all aspects of maternity care

    g. High-risk pregnant members have been referred to, and are receiving appropriate care from, a qualified physician, and

    h. Postpartum services are provided to members within 60 days of delivery.

9. Mandatory provision of initial prenatal care appointments within the established timeframes. A process, with primary verification, must be in place to monitor these appointments to ensure timeliness. The established timeframes are as follows:

    a. First trimester -- within 14 days of a request for an appointment

b. Second trimester -- within seven days of a request for an appointment

c. Third trimester -- within three days of a request for an appointment, or

d. High risk pregnancy care must be initiated within three days of identification to the member's Contractor or maternity care provider, or immediately if an emergency exists.

10. Mandatory provision of return visits in accordance with ACOG standards. A process, with primary verification, must be in place to monitor these appointments to ensure timeliness.

11. Timely provision of medically necessary transportation services as described in Chapter 300, Policy 310

12. The establishment of a specific objective for postpartum visit utilization rate. Utilization activities must be monitored and evaluated and interventions to improve the rate must be implemented.

13. Participation of Contractors in all reviews of the maternity care services program conducted by the AHCCCS Administration, including provider visits and chart audits.

C. CONTRACTOR REQUIREMENT FOR THE WRITTEN MATERNITY CARE AND FAMILY PLANNING SERVICES PLAN

Each Contractor must have a written maternity care plan that addresses minimum Contractor requirements as specified in the prior policy (numbers 1 through 13) as well as the objectives of the Contractor's program. It must also incorporate monitoring and evaluation activities for these minimum requirements. The written maternity care plan must contain, at a minimum, the following:

1. A narrative description of all planned activities to address the Contractor's minimum requirements for maternity care services. Contractors may attach relevant policies and procedures to this section.

2. A work plan containing:

   a. Specific measurable objectives. These objectives may be based on AHCCCS established minimum performance standards or other generally accepted benchmarks. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks may be used (e.g., National Committee on Quality Assurance, Healthy People 2010 standards).

   b. Strategies and activities to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the maternity care services program)

   c. Targeted implementation and completion dates of work plan activities

   d. Assessment of work plan monitoring activities and evaluation of outcomes, and

   e. A listing of staff positions responsible and accountable for meeting established goals and objectives.

3. The maternity care and family planning services plan must be submitted annually to AHCCCS Division of Health Care Management/Clinical Quality Management Unit and may be subject to approval. (See Exhibit 400-1.)

D. FEE-FOR-SERVICE (FFS) MATERNITY CARE PROVIDER REQUIREMENTS

1. Physicians and practitioners must follow the American College of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.

2. Licensed midwives must provide services within their scope of practice and use the AHCCCS standardized risk assessment form (Exhibit 410-3) in accordance with requirements specified in the Licensed Midwife Services section of this policy.

3. All maternity care providers will ensure that:

   a. High-risk members have been referred to a qualified physician and are receiving appropriate care

   b. Members are educated about health behaviors during pregnancy, including proper nutrition, smoking cessation, the physiology of pregnancy, the process of labor and delivery, breastfeeding and other infant care information

   c. The member's medical record is appropriately maintained and documents all aspects of the maternity care provided, and

   d. Members will be referred for support services to the Women, Infants and Children Supplemental Feeding Program, as well as other community-based resources, in order to support healthy pregnancy outcomes. Members must be notified that in the event they lose eligibility for services, they may contact the Arizona Department of Health Services hot line for referrals to low or no cost services.

4. Postpartum services will be provided to members within 60 days of delivery.

E. COVERED RELATED SERVICES WITH SPECIAL POLICIES

AHCCCS covered related services with special policy and procedural guidelines for fee-for-service and Contractor providers include, but are not limited to:

1. Circumcision of newborn male infants

2. Extended stays for normal newborns

3. Home uterine monitoring

4. Labor and delivery services provided in freestanding birthing centers

5. Labor and delivery services provided in a home setting

6. Licensed midwife services

7. Supplemental stillbirth payment

8. Pregnancy termination

1. CIRCUMCISION OF NEWBORN MALE INFANTS

Description. Effective October 1, 2002, under Arizona Revised Statutes Title 36-2907(b), routine circumcision for eligible newborn male infants is not a covered service.

Amount, Duration and Scope. Circumcision of newborn male infants is not a covered service unless determined to be medically necessary. The procedure requires prior authorization by the Contractor Medical Director or designee for enrolled members, or the AHCCCS Chief Medical Officer or designee for fee-for-service members.

2. INPATIENT HOSPITAL STAYS

Description: Women and their newborns are allowed to receive 48 hours of inpatient hospital care after a normal vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. A normal newborn infant may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond a 48/96 hour stay.

Amount, Duration and Scope: The mother of the newborn may be discharged prior to the minimum 48/96 hour stay if agreed upon by the mother in consultation with the physician or practitioner. In addition, if the mother's stay is to extend beyond 48/96 hours, an extended stay for the newborn should be granted if the mother's condition allows for mother-infant interaction and the child is not a ward of the State or is not to be adopted. Prior authorization is required for extended stays for newborn infants for the fee-for-service population.

3. HOME UTERINE MONITORING TECHNOLOGY

Description. AHCCCS covers medically necessary home uterine monitoring technology for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.

If the member has one or more of the following conditions, home uterine monitoring may be considered:

1. Multiple gestation, particularly triplets or quadruplets

2. Previous obstetrical history of one or more births before 35 weeks gestation, or

3. Hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis and ready to be discharged for bed rest at home.

These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit.

4. LABOR AND DELIVERY SERVICES PROVIDED IN FREESTANDING BIRTHING CENTERS

Description. For members who meet medical criteria specified in this policy, AHCCCS covers freestanding birthing centers when labor and delivery services are provided by licensed physicians or certified nurse practitioners in midwifery (a.k.a. certified nurse midwives).

Freestanding birthing centers are defined as out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services and certified by the Commission for the Accreditation of Free Standing Birth Centers. These facilities are staffed by registered nurses to provide assistance with labor and delivery services. They are equipped to manage uncomplicated low-risk labor and delivery and must be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

Amount, Duration and Scope.

1. Labor and delivery services rendered through freestanding birthing centers must be provided by a physician, (i.e., the member's primary care provider or an obstetrician with hospital admitting privileges) or by a registered nurse who is accredited/certified by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services.

2. Only pregnant AHCCCS members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a free standing birthing center. Risk status must be determined by the attending physician or certified nurse midwife using the standardized assessment tools for high-risk pregnancies (American College of Obstetricians and Gynecologists, Mutual Insurance Company of Arizona, or National Association of Childbearing Centers). In any area of the risk assessment where standards conflict, the most stringent will apply. The age of the patient must also be a consideration in the risk status evaluation; generally members less than 18 years of age are considered high risk.

5. LABOR AND DELIVERY SERVICES PROVIDED IN THE HOME

Description. For members who meet medical criteria specified in this policy, AHCCCS covers labor and delivery services provided in the home by licensed physicians, practitioners (physician assistants or certified nurse practitioners in midwifery) and licensed midwives.

Amount, Duration and Scope. Only pregnant AHCCCS members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver in the member's home.

Risk status must be determined by:

1. The attending physician, physician assistant or certified nurse midwife using the standardized assessment tools for high-risk pregnancies from the Mutual Insurance Company of Arizona or the American College of Obstetricians and Gynecologists; or

2. The licensed midwife using the AHCCCS standardized risk assessment form (Exhibit 410-3) in accordance with requirements specified in the Licensed Midwife Services section of this policy.

Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery.

Licensed midwives who render home labor and delivery services must have, for each anticipated home labor and delivery, an established plan of action including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided. In addition, referral information must be obtained regarding an AHCCCS registered physician who can be contacted immediately in the event that management of complications is necessary.

Upon delivery of the newborn, the physician, practitioner, or licensed midwife is responsible for conducting newborn examination procedures and referring the member and infant to a physician for follow-up care of any assessed problematic conditions (licensed midwives refer to Exhibit 410-3, Sections III and IV). In addition, the provider must notify the mother's Contractor of the birth, or the AHCCCS Newborn Reporting Line for infants born to fee-for-service mothers. Notification should be given no later than three days after the birth in order to properly enroll the newborn with AHCCCS.

6. LICENSED MIDWIFE SERVICES

Description. AHCCCS covers maternity care and coordination provided by licensed midwives, within their scope of practice, for fee-for-service (FFS) members or enrolled members if licensed midwives are included in the Contractor provider network. In addition, members must meet eligibility and medical criteria specified in this policy and choose to receive maternity services from this provider type.

Amount Duration and Scope. Licensed midwife services may be provided only to members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. The age of the member must be included as a consideration in the risk status evaluation. Risk status must initially be determined at the time of the first visit and each trimester thereafter by either:

1. The member's attending physician or practitioner using the standardized assessment criteria and protocols for high-risk pregnancies from the American College of Obstetrics and Gynecology or Mutual Insurance Company of Arizona, or

2. The licensed midwife using the AHCCCS standardized assessment form and evaluation criteria included in Exhibit 410-3 of this Chapter.

Before providing licensed midwife services, documentation certifying risk status of the member's pregnancy must be submitted to the member's Contractor, or the AHCCCS Division of Fee-for-Service Management (DFSM) prior authorization (PA) Unit for FFS members. In addition, a disclosure form, signed and dated by the member, must be submitted indicating that the member has been informed and understands the scope of services that will be provided by the licensed midwife. Members initially determined to have a high-risk pregnancy, or members whose physical condition changes to high-risk during the course of pregnancy, must immediately be referred to an AHCCCS registered physician within the provider network of the member's Contractor for maternity services. The AHCCCS DFSM PA unit must be notified of all FFS members determined to be high risk and the name of the physician to whom the member was referred.

Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have a plan of action including the name and address of an AHCCCS registered physician and an acute care hospital, in close proximity to the planned location of labor and delivery, for referral in the event that complications should arise. This plan of action must be submitted with the assessment form, Exhibit 410-3, to the AHCCCS Chief Medical Officer or designee for FFS members or to the Contractor Medical Director or designee for members enrolled with a Contractor.

Upon delivery of the newborn, the licensed midwife is responsible for conducting newborn examination procedures, and referring the member and infant to a physician for follow-up care of any assessed problematic conditions.

In addition, the licensed midwife must notify the mother's Contractor of the birth, or the AHCCCS Administration Newborn Reporting Line for infants born to FFS mothers, no later than three days after the birth in order to properly enroll the newborn with AHCCCS.

7. SUPPLEMENTAL DELIVERY PAYMENT

Description. A supplemental payment package was implemented for Contractors to cover the cost of delivery services. The supplemental payment ("kick") applies to all births to women enrolled with Contractors.

AHCCCS also pays this supplement to Contractors when the child is stillborn. Stillbirth refers to those infants, either pre-term or term, delivered in the third trimester of a documented pregnancy, who were born dead. In order for Contractors to be eligible to receive this payment for a delivery of a stillborn child, the following criteria must be met:

1. The stillborn infant must have

    a. Attained a weight of at least 600 grams, or

    b. Attained a gestational age of at least 24 weeks, as verified by a physician's prenatal records and/or history and physical with estimated date of normal delivery, or

    c. Attained a documented gestational age of at least 24 weeks at time of delivery by use of the Ballard system of evaluation for age assessment. Testing for gestational age can be performed by either nursing or physician staff in attendance at the time of delivery of the stillborn child.

2. For stillbirths meeting one of the above medical criteria, Contractors must submit medical documentation with the "Request for Stillbirth Supplement" form (Exhibit 410-5) to:

    AHCCCS
    Division of Health Care Management
    Clinical Quality Management Unit/MCH Manager
    701 E. Jefferson, MD 6500
    Phoenix, AZ 85034

Exclusions. No supplemental payment is provided for labor and delivery services rendered during the prior period coverage timeframe.

Contractor requests for the payment must be made within six months of the delivery date unless an exemption is granted by the Clinical Quality Management Unit at AHCCCS. Exemptions will be considered on a case-by-case basis.

8. PREGNANCY TERMINATION

Description. AHCCCS covers pregnancy termination if one of the following conditions is present:

1. The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.

2. The pregnancy is a result of rape or incest.

3. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:

    a. Creating a serious physical or mental health problem for the pregnant member

    b. Seriously impairing a bodily function of the pregnant member

    c. Causing dysfunction of a bodily organ or part of the pregnant member

    d. Exacerbating a health problem of the pregnant member, or

    e. Preventing the pregnant member from obtaining treatment for a health problem.

Conditions, Limitations and Exclusions.

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination (see Exhibit 410-1).

This form must be submitted to the appropriate assigned Contractor Medical Director or designee for enrolled pregnant members, or the AHCCCS Chief Medical Officer or designee for fee-for-service (FFS) members. The Certificate must certify that, in the physician's professional judgment, one or more of the above criteria have been met.

Additional Required Documentation

1. A written informed consent must be obtained by the provider and kept in the member's chart for all pregnancy terminations. If the pregnant member is under 18 years of age, or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101), a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.

2. When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed.

NOTE: Contractors must submit a standardized monthly Pregnancy Termination report (Exhibit 410-2) to AHCCCS/Division of Health Care Management which documents the number of pregnancy terminations performed during the month. If no pregnancy terminations were performed during the month, the monthly report must still be submitted to attest to that information.

When pregnancy terminations have been authorized by the Contractor, the following information must be provided with the monthly report:

1. A copy of the completed Certificate of Necessity for Pregnancy Termination which has been signed by the Contractor Medical Director or designee, and

2. A copy of the official incident report in the case of rape or incest.

(See Exhibit 410-2 for the reporting form and Exhibit 400-1 for submission timeframes.)

Prior authorization (PA). Except in cases of medical emergencies, the provider must obtain PA for all covered pregnancy terminations from the Contractor Medical Director, or his/her designee. PA for FFS pregnant members must be obtained from the AHCCCS Chief Medical Officer or designee. A completed Certificate of Necessity for Pregnancy Termination must be submitted with the request for PA. The Contractor Medical Director or AHCCCS Chief Medical Officer or designee will review the request and the Certificate, and expeditiously authorize the procedure if the documentation establishes the termination of pregnancy to be a medically necessary covered service.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Contractor, or AHCCCS/Division of Fee for Service Management Prior Authorization Unit, within two working days of the date on which the pregnancy termination procedure was performed.

The following references apply to all information contained in this policy.

Refer to Chapter 500 for AHCCCS policy on the transfer of a neonate between acute care centers.

Refer to Chapter 800 for AHCCCS/DFSM FFS policy regarding extended stays for normal newborns.

Refer to Chapter 900 for quality management for all covered services.

EXHIBIT 410-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF NECESSITY FOR PREGNANCY TERMINATION

EXHIBIT 410-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF NECESSITY FOR PREGNANCY TERMINATION

JUSTIFICATION FOR PREGNANCY TERMINATION (CHECK ONE AND PROVIDE ADDITIONAL RATIONALE):

☐ **LIFE OF MOTHER ENDANGERED**

_____

_____

☐ **RAPE**
Reported to authorities, pursuant to A.R.S. Section 13-3620 or A.R.S. Section 46-454 Yes _____ No _____
If yes, to what Agency? _____

Report #: _____ Date filed: _____

☐ Incident report attached.

☐ **INCEST**
Reported to authorities, pursuant to A.R.S. Section 13-3620 or A.R.S. Section 46-454 Yes _____ No _____

If yes, to what Agency?_____

Report #: _____ Date filed: _____

☐ Incident report attached._____

☐ **MEDICALLY NECESSARY**

_____

_____

Member Name: _____
Last First Middle

Member Address: _____

_____

_____

Date of Birth: _____

Member AHCCCS ID #: _____

Facility: _____

Date of Service: _____

Procedure Code(s): _____

Health Plan: _____

_____
Physician's Printed Name

_____
Physician's Phone

_____
Fax

Physician Signature: _____ Date:_____

Prior Authorization Number: _____ Date: _____

Denial Reason: _____ Date: _____

Contractor Medical Director/AHCCCS Chief Medical Officer Signature: _____

Revised February, 2003

EXHIBIT 410-2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
MONTHLY PREGNANCY TERMINATION REPORT

EXHIBIT 410-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
MONTHLY PREGNANCY TERMINATION REPORT

Contractor Name**:** _____

Reporting Period: _____
Month Year

Name of Individual completing form: _____
Name Title

If the Contractor has not authorized any termination of pregnancies for the month, indicate with a zero here: _____

When terminations have been authorized by the Contractor, the following information must be provided:

*Reason:	**Age:	AHCCCS Member ID	Rate Code	Procedure Code	Amount Paid
1.					
2.					
3.					
4.					

Choose one of the following codes:

***Reasons for Termination**

A. Life of Mother Endangered
B. Result of Incest
C. Result of Rape
D. Medically Necessary

****Age/Condition**

(a) Under 18 years of age
(b) Incapacitated, over 18 years of age
(c) 18 years of age and older

Attach to this report for each approved pregnancy termination:
- A copy of the AHCCCS Certificate of Necessity; and
- A copy of the official incident report when rape or incest is involved.

Mark the envelope **confidential** and send the completed information to the following address:

Arizona Health Care Cost Containment System
Division of Health Care Management
Clinical Quality Management Unit
701 East Jefferson, MD 6700
Phoenix, AZ 85034

DO NOT FAX

ANY REQUIRED INFORMATION THAT IS NOT AVAILABLE AT THE TIME OF THIS REPORT MAY BE INCLUDED IN THE NEXT MONTH'S REPORT.

Revised: February 2003, August 2001

EXHIBIT 410-3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
RISK ASSESSMENT TOOL SPECIFIC TO THE PROVISION OF
LOW RISK MATERNITY/DELIVERY CARE SERVICES BY LICENSED MIDWIVES
(PRIOR AUTHORIZATION FORM)

EXHIBIT 410-3
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
RISK ASSESSMENT TOOL SPECIFIC TO THE PROVISION OF
LOW RISK MATERNITY/DELIVERY CARE SERVICES BY LICENSED MIDWIVES
(PRIOR AUTHORIZATION FORM)
Revised 8-1-2005

DATE:_____ MIDWIFE NAME:_____ PROVIDER # _____

STREET ADDRESS:_____ CITY: _____

RECIPIENT NAME:_____ AHCCCS ID: _____

COUNTY:_____ STATE:_____ ZIP:_____

TELEPHONE:_____

A Score of 3 (specific to each condition not accumulative) requires immediate transfer to a physician, and scores of 2 require consultation with a physician, (See A.A.C. R9-16-108 to R9-16-110). AHCCCS specific requirements in addition to Rule are identified by an asterisk (*). The requirement for continued prior authorization approval is dependent upon three submissions of this form at set intervals - Initial visit, between 32-36 weeks gestation, and immediate postpartum.

I. INITIAL SCREEN (Presentation)

			SCORE (Circle)
A.		**Socio-Demographic Factors:**	
*	1.	No assistance at home.	2
*	2.	Recipient residence over 1 hour for midwife travel.	1.5
	3.	Chronological age:	
	a.	Nulliparous over 40	2
*	b.	Multiparous over 45	2
	c.	Younger than 16 years of age.	2
B.		**Maternal Medical History:**	
	1.	Cardiovascular:	
	a.	Chronic hypertension	3
	b.	Heart disease:	3
		i. Valve replacement or other serious condition.	
		ii. Mitral valve prolapse	2-3
	c.	Congenital heart defects	3
	d.	Pulmonary embolus	3
	2.	Urinary System:	
	a.	Renal disease moderate to severe including nephritis or chronic renal disease.	3
*	b.	One episode of pyelonephritis prior to this pregnancy.	2
	3.	Psycho-Neurological:	
	a.	History of severe psychiatric illness in the 6 month period prior to pregnancy.	3
*	b.	Previous psychotic episode diagnosed by psychiatric evaluation.	2
*	c.	Current mental health problem requiring treatment or management with medication.	2
	d.	Epilepsy or seizures.	2

				SCORE (Circle)
	*	e.	Current required use of anticonvulsant drugs	2
		f.	Drug addiction (heroin, barbiturates, ETOH, cocaine, crack), current use of drugs, or therapy for drug abuse.	3
	*	g.	Cigarette smoking:	
			(1) < one pack/day.	1
			(2) > one pack/day.	1.5
	*	h.	Severe recurring migraines necessitating medication	2
4.			Endocrine:	
		a.	Diabetes mellitus	3
	*	b.	Thyroid disease:	
			(1) History of thyroid surgery.	2
			(2) Enlarged thyroid with symptoms of thyroid disease and/or abnormal laboratory tests.	2
			(3) Current use of thyroid stimulating medications.	2
			(4) Current use of thyroid suppressing medications.	2
5.			Respiratory:	
		a.	Active tuberculosis	3
	*	b.	Asthma and/or chronic bronchitis within the last 5 years.	1
6.			Other Systems:	
		a.	Bleeding disorder and/or hemolytic disease.	3
	*	b.	Previous breast surgery for malignancy.	2-3
	*	c.	Other serious medical problems_____ .	2-3
7.			H_x of severe postpartum bleeding, of unknown cause, which required transfusion.	3
8.			Active syphilis.	3
9.			Active hepatitis or active gonorrhea until treated and recovered, following which midwife care may resume.	3
10.			Primary genital herpes simplex infection in first trimester.	3
*11.			Refusal of RH blood work or treatment.	2

C. Maternal Obstetrical History:

	*	1.	EDC < 12 months from date of previous delivery.	1.5
		2.	Previous Rh sensitization.	3
		3.	Parity greater than five	2
		4.	Use of fertility drugs to achieve this pregnancy.	2-3
	*	5.	3 or more spontaneous abortions (12-28 weeks)	2
		6.	Previous uterine surgery including cesarean section.	3
	*	7.	Previous ectopic pregnancy	2
*		8.	Previous cone biopsy.	2
	*	9.	Previous abruptio placentae.	2
*		10.	Previous placenta previa or significant 3rd trimester bleeding.	2-3
		11.	Severe hypertensive disorder during previous pregnancy (eclampsia).	3
	*	12.	History of prolonged labor:	
			a. First labor: stage I > 24 hours, stage II > 3 hours, and/or stage III > 1 hour.	1
			b. Subsequent labors: stage I > 18 hours, stage II > 2 hours.	1

D. History Related to Previous Infants:

		1.	Stillbirth	2
	*	2.	Birth weight (< 2500 grams or > 4500 grams).	1
	*	3.	Major congenital malformations.	1
	*	4.	Genetic metabolic disorder (genetic counseling).	1-2

			SCORE (Circle)
E.	**Maternal Physical Findings**		
	1.	Length of gestation at registration;	
		*a. < 26 weeks.	0
		*b. 26-30 weeks (labs normal and dates consistent).	1
		*c. 30-32 weeks (labs normal and dates consistent).	1
		*d. > 32 weeks.	2
		*e. Gestational age > 34 weeks with no prenatal care	3
	* 2.	Weight for height outside normal range (see attached sheet).	0-2
	* 3.	Clinical evidence of uterine malformations or adnexal mass	2

DISPOSITION:

Initial Screen: (Circle) Eligible
Not Eligible Because: _____

Referred to: _____

II. ANTEPARTUM REFERRAL/TRANSFER AND CONSULTATION FACTORS

			SCORE (Circle)
A.	**Medical Complications:**		
	1.	Rh disease with positive titers.	3
	2.	A blood pressure of 140/90 or an increase of 30mm Hg systolic or 15mm Hg diastolic over client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart.	3
	3.	Hematocrit/Hemoglobin:	
		a. A persistent hemoglobin < 10gm/dl or a hematocrit < 30% during the third trimester.	3
	*	b. Hematocrit < 32% or hemoglobin < 10.5 gm/dl at 37 weeks.	2
	4.	A pelvis that will not safely allow a baby to pass through during labor.	3
	5.	Severe, persistent headaches, with visual disturbances, stomach pains, or swelling of the face and hands.	2
	6.	Greater than 1 + sugar, ketones, or protein in the urine on two consecutive visits.	2
	7.	Excessive vomiting or continued vomiting after 20 weeks gestation.	2
	8.	A fever of 100.4° Fahrenheit or 38° Centigrade twice at 24 hours apart.	2
	9.	Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful.	2
	10.	Testing positive for HIV.	2
	11.	Deep vein thrombophlebitis or pulmonary embolism.	3
B.	**Obstetric Complications:**		
	1.	Prematurity or labor beginning before 36 weeks gestation.	3
	2.	Multiple gestation in the current pregnancy.	3
	3.	Gestation beyond 42 weeks.	3
	4.	Presence of ruptured membranes without onset of labor within 24 hours.	3
	5.	Abnormal fetal heart rate of below 120 beats per minute or above 160 beats per minute.	3
	6.	Failure to auscultate fetal heart tones by 22 weeks gestational age.	2
	7.	Measurements for fetal growth are not within 2cm of gestational age.	2
	8.	Failure to gain 12 pounds by 30 weeks gestation or gaining more than 8 pounds in any two week period during pregnancy.	2
	9.	An abnormal presentation after 36 weeks.	2
	10.	Effacement or dilation of the cervix, greater than a fingertip, accompanied by contractions, prior to 36 weeks gestation.	2
	11.	Symptoms of decreased fetal movement.	2
C.	**Environmental Factors:**		
*	1.	Lack of electricity	1-2
*	2.	Lack of available water source.	1-2
*	3.	Consistent non-attendance at prenatal visits.	2-3
*	4.	Lack of available support person in the home for first 3 post partum days.	3
	5.	An unsafe location for delivery.	3

DISPOSITION:

Initial Screen: (Circle): Eligibility Continued
Not Eligible Because: _____

Referral to: _____

III. LABOR/POSTPARTUM REFERRAL/TRANSFER AND CONSULTATION FACTORS

			SCORE (Circle)
A		**Maternal Factors:**	
	1.	Active genital herpes at the onset of labor.	3
	2.	A pelvis that will not safely allow a baby to pass through during labor.	3
	3.	A severe psychiatric illness evident during assessment of recipient's preparation for birth.	3
	4.	Presence of ruptured membranes without onset of labor within 24 hours.	3
	5.	A post partum hemorrhage of greater than 500cc in the current pregnancy.	3
	6.	A fever of 100.4° Fahrenheit or 38° Centigrade twice at 24 hours apart.	2
	7.	Second degree or greater lacerations of the birth canal.	2
	8.	Failure of the uterus to return to normal size in the current postpartum period.	2
	9.	Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful.	2
	10.	Lack of progress in labor:	
	* a.	First stage: Lack of steady progress in dilation and descent after 24 hours in nulliparas and 18 hours in multiparas.	2
	* b.	Second stage: > 2 hours without progress in descent.	2
	* c.	Third stage: > 1 hour	2
*	11.	Marked cervical edema.	2
*	12.	Intrapartum blood loss > 500cc	2
*	13.	Evidence of infectious process.	2
*	14.	Development of other severe medical/surgical problems and/or condition requiring more than 12 hours of postpartum observation.	2
*	15.	Non-bleeding placenta retained more that 40 minutes	3
B.		**Fetal Factors:**	
	1.	Abnormal fetal heart rate of below 120 beats per minute or above 160 beats per minute.	3
	2.	Presence of thick meconium, blood-stained amniotic fluid or abnormal fetal heart tones.	3
	3.	An unengaged head at seven centimeters dilation in active labor.	2
*	4.	Presence of light/moderate meconium staining.	2
*	5.	Estimated fetal weight < 2500 gm or > 4500 gm.	2
*	6.	Umbilical cord prolapse.	3

DISPOSITION:

Initial Screen: (Circle) Eligibility Continued
Not Eligible Because:_____

Referred to: _____

IV. INFANT REFERRAL/TRANSFER AND CONSULTATION FACTORS

(Circle)			SCORE
	1.	Birth weight less than 2000 grams.	3
	2.	Pale blue or gray color after ten minutes.	3
	3.	Excessive edema.	3
	4.	Major congenital anomalies.	3
	5.	Respiratory distress.	3
	6.	Weight less than 2500 grams or 5 lbs., 8 oz.	2
	7.	Congenital anomalies.	2
	8.	An Apgar score less than seven at five minutes.	2
	9.	Persistent breathing at a rate of more than 60 breaths per minute.	2
	10.	An irregular Heartbeat.	2
	11.	Persistent poor muscle tone.	2
	12.	Less than 36 weeks gestation or greater than 42 weeks gestation by gestation exam.	2
	13.	Yellow colored skin within 48 hours.	2
	14.	Abnormal crying.	2
	15.	Meconium staining of the skin.	2
	16.	Lethargy, irritability, or poor feeding.	2
	17.	Excessively pink coloring over entire body.	2
	18.	Failure to urinate or pass meconium in the first 24 hours of life.	2
	19.	A hip examination which results in a clicking or incorrect angle.	2
	20.	Skin rashes not commonly seen in the newborn.	2
	21.	Temperature persistently above 99.0° or below 97.6° Fahrenheit.	2
*	22.	Signs of Pre or Post-maturity.	1-2
*	23.	Persistent Hypothermia (< 97° rectal after 2 hours of life).	2
*	24.	Exaggerated Tremors	2
*	25.	Any condition requiring > 12 hours of post-delivery observation.	2

BIRTH OUTCOME

Delivery Date:_____ EDC:_____ Time:_____ Infant Sex:_____ Weight: _____

Apgar Score: (Circle) 1 minute 5 minute (Circle) Breast Bottle Feed

Infant Prophylactic Procedures: Yes No (if no indicate if waivers are signed)

Infant Transfer Date and Time if Sick: _____Newborn Screening Done: (Circle) Yes No

Postpartum:

Vital Signs Stable____ Voiding____ Foods/Fluids_____ Lab Work if Rh Negative_____ Laceration_____ (Degree) _____

Fundus _____

Mother

Referral Date:_____Physician Name:_____Outcome: _____

Transported: Yes No Hospital _____

Infant

Referral Date:_____Physician Name:_____Outcome:_____

Transported: Yes No Hospital: _____

Social Service: WIC:_____Family Planning:_____Domestic Violence:_____Other: _____

EXHIBIT 410-4

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
SEMIANNUAL HIV/AIDS PREGNANT WOMEN REPORT

EXHIBIT 410-4

Arizona Health Care Cost Containment System
Semiannual HIV/AIDS Pregnant Women Report

Each Contractor must report to AHCCCS the number of pregnant women who have been identified as HIV/AIDS positive. This report is due no later than 30 days after the end of the second and fourth quarters of each contract year (due by April 30 and October 30).

Contractor Name: _____

Reporting Period: _____ October 1 through March 30

_____ April 1 through September 30

Name of Person Completing Form: _____
Name

_____
Title

Please report the number of new cases of pregnant women enrolled with your Contractor who have been identified as HIV/AIDS positive during this reporting period (not cumulatively).

_____

Mark the envelope confidential and send the completed information to the following address:

Arizona Health Care Cost Containment System
Division of Health Care Management
Clinical Quality Management Unit
701 East Jefferson, Mail Drop 6700
Phoenix, AZ 85034

PLEASE DO NOT FAX

Revised: 04/01/2004

EXHIBIT 410-5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
REQUEST FOR STILLBIRTH SUPPLEMENT

EXHIBIT 410-5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
REQUEST FOR STILLBIRTH SUPPLEMENT

CONTRACTOR: _____

Infant Name: _____ Date of Delivery: _____

Place of Delivery: _____

Mother's Name: _____ AHCCCS ID #: _____

Mother's Address: _____

Cause of Stillbirth (if known): _____

Application must be accompanied by one or more of the following forms:

a) Neonatal I or similar hospital document, or
b) Physician obstetrical prenatal records (history and physical) identifying EDC, or
c) Ballard assessment (physical maturity rating) done at delivery or shortly thereafter by nursing and/or physician staff.

Send to: AHCCCS Administration
Division of Health Care Management/CQM
Maternal & Child Health Manager
701 E. Jefferson, MD 6700
Phoenix, AZ 85034

The following is to be completed by the AHCCCS Division of Health Care Management staff:

Request Approved: _____

Request Denied: _____

Explanation: _____

_____

Authorized Signature Date

Initial Effective Date: 04/01/2004

420 FAMILY PLANNING

Description. Family planning services are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Family planning and family planning extension services include covered medical, surgical, pharmacological and laboratory benefits specified in this policy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. Members may choose to obtain family planning services and supplies from any appropriate provider within the Contractor's network.

Amount, Duration and Scope. Members (male and female) who are eligible to receive full health care coverage and are enrolled with a Contractor, or are receiving services through fee-for-service (FFS), may elect to receive family planning services in addition to other covered services.

Members whose SOBRA (Sixth Omnibus Budget Reconciliation Act) postpartum eligibility has expired (Arizona Revised Statutes § 36-2907.04) and are enrolled with a Contractor, or are receiving services on a FFS basis, are eligible to receive family planning extension services for up to 24 months. Family planning extension services include only those services related to family planning; other services are not covered.

Members who are enrolled with a Contractor at the time SOBRA eligibility expires will remain with their Contractor; they may remain with their assigned maternity provider or exercise their option to select another provider from the Contractor's provider network for family planning extension services. Members receiving services on a FFS basis may elect to remain with their attending FFS physician, select a new FFS provider or a new Contractor for family planning extension services.

Family planning services for members eligible to receive full health care coverage and members eligible to receive family planning extension services may both receive the following medical, surgical, pharmacological and laboratory services:

1. Contraceptive counseling, medication, supplies, including, but not limited to: oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams and suppositories

2. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies, related to family planning

3. Treatment of complications resulting from contraceptive use, including emergency treatment

4. Natural family planning education or referral to qualified health professionals, and

5. Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse.

Coverage for the following family planning services varies based upon eligibility status as indicated in the matrix below.

SERVICES	AHCCCS ACUTE CARE, ALTCS AND FFS MEMBERS	FEMALE MEMBERS * RECEIVING FAMILY PLANNING EXTENSION SERVICES
Pregnancy Screening	Covered service	Covered only when completed prior to provision of long-term contraceptives.
Pharmaceuticals	Covered service when associated with medical conditions related to family planning or other medical conditions.	Covered service only when associated with medical conditions related to family planning.
Screening and treatment for sexually transmitted diseases (STDs)	Both screening and treatment for STDs are covered services.	Screening services for STDs are covered but treatment services are not provided through AHCCCS - a referral is made to an agency, which provides low or no cost STD treatment services.
Sterilization	Services are covered for both male and female members when the requirements specified in this policy for sterilization services are met.	Services are covered for female members when the requirements specified in this policy for sterilization are met.

* Family planning extension services are available only to female members who have lost SOBRA eligibility; men are not eligible for these services.

LIMITATIONS

The following are not covered for the purpose of family planning or family planning extension services:

1. Infertility services including diagnostic testing, treatment services or reversal of surgically induced infertility

2. Pregnancy termination counseling

3. Pregnancy terminations and hysterectomies, or

4. Hysteroscopic tubal sterilization (such as the Essure Micro-Insert).

Refer to Chapter 800 - FFS Quality and Utilization Management for prior authorization requirements for FFS providers.

A. CONTRACTOR REQUIREMENTS FOR PROVIDING FAMILY PLANNING SERVICES

Contractors must ensure that service delivery, monitoring and reporting requirements are met.

Contractors must:

1. Plan and implement an outreach program to notify members of reproductive age of the specific covered family planning services available to them and how members may request them. Notification must be in accordance with A.R.S. § 36.2904(L). The information provided to members must include, but is not limited to:

   a. A complete description of covered family planning services available

   b. Information on how to request/obtain these services and that assistance with scheduling is available, and

   c. A statement that there is no charge for these services.

2. Have policies and procedures in place to ensure that maternity care providers are educated regarding covered and non-covered services available to AHCCCS members, including family planning services.

3. Have family planning services that are:

   a. Provided in a manner free from coercion or mental pressure

   b. Available and easily accessible to members

   c. Provided in a manner which assures continuity and confidentiality

   d. Provided by, or under the direction of, a qualified physician or practitioner, and

   e. Documented in the medical record. In addition, documentation should be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning.

4. Provide translation/interpretation of information related to family planning in accordance with requirements of the AHCCCS Division of Healthcare Management "Cultural Competency" policy, available from the AHCCCS Contractor Operations Manual (available online from the AHCCCS Web site at www.ahcccs.state.az.us)

5. Incorporate medical audits for family planning services within quality management activities to determine conformity with acceptable medical standards.

6. Establish quality/utilization management indicators to effectively measure/monitor the utilization of family planning services

7. Have written practice guidelines that detail specific procedures for the provision of long-term contraceptives. These guidelines shall be written in accordance with acceptable medical standards, and

8. In addition, Acute Care Contractors, as a part of the provision of family planning extension services, must:

   a. Assist providers in establishing procedures for referral of members, who are screened and determined to have sexually transmitted disease, to an agency which provides low/no cost treatment for members receiving family planning extension services, and

   b. Assist providers in establishing procedures for referral of those members who lose AHCCCS eligibility to low/no cost agencies for family planning services.

B. PROTOCOL FOR MEMBER NOTIFICATION OF FAMILY PLANNING AND FAMILY PLANNING EXTENSION SERVICES AND CONTRACTOR REPORTING REQUIREMENTS

Contractors are responsible for providing family planning services and notifying their members regarding these AHCCCS covered services. Acute Care Contractors are also responsible for the provision of family planning extension services and information regarding these services. Contractors are responsible for reporting sterilization of SOBRA (Sixth Omnibus Budget Reconciliation Act) members, which will result in either ineligibility for or termination of AHCCCS family planning extension services for those members.

The AHCCCS Administration will notify all SOBRA members if their eligibility for full health care coverage is reduced to family planning extension services only, and/or when members have lost eligibility for family planning extension services. In addition, AHCCCS Administration will provide information about AHCCCS covered family planning services and family planning extension services to members who receive services on a fee-for-service basis.

Member notification of these covered services must meet the following minimum requirements:

1. Notification shall be in accordance with A.R.S. § 36.2904(L).

2. The requirement for notification is in addition to the member handbook and the member newsletter. Brochures, fliers and letters dealing specifically with notification of family planning services are acceptable methods of providing this information. The brochures, fliers and letters must be approved by AHCCCS and conform to confidentiality requirements.

3. Notification is to be given at least once a year and must be completed by November 1. For Contractor members who enroll after November 1, notification will be sent at the time of enrollment.

4. Notification must include all of the family planning services covered through AHCCCS as well as instructions to members regarding how to access these services. Acute Care Contractors must also provide such information to members regarding family planning extension services.

5. Notification must be written at a reading level appropriate for the membership.

6. Notification must be presented in a second language in accordance with the requirements of the AHCCCS Division Of Health Care Management "Cultural Competency" policy, available in the AHCCCS Contractor Operations Manual (available on the AHCCCS Web site at www.ahcccs.state.az.us)

7. Contractors must implement procedures to ensure that primary care providers (PCP) verbally notify members of the availability of family planning services at least annually during member visits to their PCP.

8. Acute Care Contractors' maternity care providers must also provide information regarding family planning extension services to assigned SOBRA members during their postpartum visit(s)

9. Contractors must report to AHCCCS Division of Member Services (DMS) any member who receives a sterilization procedure during SOBRA eligibility. Reporting information must include the member's name, AHCCCS identification number, date of birth, and date of sterilization. The Contractor must either:

    a. Inform the AHCCCS DMS Newborn Reporting Unit at (602) 417-7400 or 1-800-228-6411 of the sterilization at the same time as the report of the newborn member (for sterilizations performed at the time of delivery of a child), or

b. Timely inform the AHCCCS DMS Verification Unit at (602) 417-7000 of sterilization of SOBRA members performed at any time during the 24-month coverage of family planning extension services.

C. FEE-FOR-SERVICE (FFS) FAMILY PLANNING PROVIDER REQUIREMENTS

FFS providers of family planning services must comply with the following:

1. Register as an AHCCCS provider and obtain an AHCCCS provider identification number

2. Comply with AHCCCS policy for family planning services and family planning extension services

3. Comply with AHCCCS Division of Fee for Service Management prior authorization requirements for prescriptions and/or related family planning supplies, and

4. Make referrals to appropriate medical professionals for services that are beyond the scope of family planning services. Such referrals are to be made at the family planning provider's discretion. If the member is eligible for full health care coverage, the referral must be made to an AHCCCS FFS provider.

D. STERILIZATION

The following AHCCCS requirements regarding member consent for covered sterilization services apply to Contractors and fee-for-service (FFS) providers. Reporting requirements for sterilization of SOBRA members only apply to Contractors. (See the above policy entitled "Protocol for Member Notification of Family Planning and Family Planning Extension Services and Contractor Reporting Requirements".)

Sterilization of a member can occur when:

1. The member is at least 21 years of age at the time the consent is signed (See Exhibit 420-1.)

2. Mental competency is determined

3. Voluntary consent was obtained without coercion

4. Thirty days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery, or

5. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Any member requesting sterilization must sign an appropriate consent form and must first have been offered factual information including:

1. Consent form requirements

2. Answers to questions asked regarding the specific procedure to be performed

3. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits

4. A description of available alternative methods

5. A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used

6. A full description of the advantages or disadvantages that may be expected as a result of the sterilization

7. Notification that sterilization cannot be performed for at least 30 days post consent

8. Suitable arrangements should be made to ensure that the information in the consent form is effectively communicated to members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as members with visual and/or auditory limitations, and

9. A witness present when consent is obtained.

Sterilization consents may **NOT** be obtained when a member:

1. Is in labor or childbirth

2. Is seeking to obtain, or is obtaining, a pregnancy termination, or

3. Is under the influence of alcohol or other substances that affect that member's state of awareness.

EXHIBIT 420-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CONSENT FORM

EXHIBIT 420-1
CONSENT FORM

42 CFR, Pt. 441, Subpart F, Appendix
10-01-02 Edition

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____. When I first asked for the information,
(doctor or clinic)
I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am not getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____
(doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)

☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
(name of individual)
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon
_____ on _____
Name: individual to be sterilized *Date: sterilization operation*
I explained to him/her the nature of the sterilization operation _____, the fact that it is intended
specify type of operation
to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested:

☐ Premature delivery
Individual's expected date of delivery: _____
☐ Emergency abdominal surgery:
(describe circumstances):

_____
Physician
Date _____

Revised 5/2003

430 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

Description. EPSDT services provide comprehensive health care, as defined in Arizona Administrative Code (9 A.A.C. 22, Article 2) through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening. Limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

Refer to Appendix B for the AHCCCS EPSDT Tracking Forms which are to be used by providers to document all age-specific, required information related to EPSDT screenings and visits.

Amount, Duration and Scope. EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR 441.58). Contractors must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule. The AHCCCS EPSDT Periodicity Schedule is intended to meet reasonable and prevailing standards of medical and dental practice and specifies screening services at each stage of the child's life (see Exhibit 430-1). The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary should be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in this Policy.

A. EPSDT DEFINITIONS

1. Early means in the case of a child already enrolled with an AHCCCS Contractor as early as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.

2. Periodic means at intervals established by AHCCCS Administration for screening to assure that a condition, illness, or injury is not incipient or present.

3. Screening means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children and youth, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

4. Diagnosis means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and X-rays, when appropriate.

5. Treatment means any type of health care or services recognized under the State Plan and Title XIX of the Social Security Act to prevent or ameliorate a condition, illness, or injury or prevent or correct abnormalities detected by screening or diagnostic procedures.

B. SCREENING REQUIREMENTS

Comprehensive periodic screenings must be performed by a clinician according to the time frames identified in the AHCCCS EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Periodicity Schedule, and inter-periodic screenings as appropriate for each member. Contractors must ensure that the newborn screening tests are conducted, including initial and second screening, in accordance with A.A.C. R9-14-502.

The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. EPSDT screenings must include the following:

1. A comprehensive health and developmental history, including growth and development screening (42 CFR 441.56(B)(1) which includes physical, nutritional and behavioral health assessments (See Appendix I, Body Mass Index Charts).

   As of January 1, 2006, the Parental Evaluation of Developmental Status (PEDS) developmental screening tool should be utilized for developmental screening by all participating primary care providers (PCPs) who care for EPSDT-age members who were admitted to the Neonatal Intensive Care Unit (NICU) following birth. The PEDS screening should also be conducted at each EPSDT well child visit for this sub-population of EPSDT members.

The PEDS tool may be obtained from www.pedstest.com or www.forepath.org.

Refer to Subsection 430-D of this Policy for PCP training and reimbursement.

2. A comprehensive unclothed physical examination

3. Appropriate immunizations according to age and health history

4. Laboratory tests (including blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test)

5. Health education

6. Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, conducted by a physician, physician's assistant or nurse practitioner

7. Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate therapies, including speech therapy, are also covered under EPSDT.

   Contractors must ensure that:

   a. Each hospital or birthing center screens all births using a physiological hearing screening method prior to initial discharge

   b. Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screen. Outpatient screening must be scheduled at the time of the initial discharge and completed between 2 and 6 weeks of age.

   c. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family is referred to a medical home for appropriate assessment, and

   d. All infants with confirmed hearing loss receive services before turning 6 months of age.

8. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:

   a. Confirmed or suspected as having TB

   b. In jail or prison during the last five years

   c. Living in a household with an HIV-infected person or the child is infected with HIV, and

   d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

C. EPSDT SERVICE STANDARDS

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT Periodicity Schedule. The AHCCCS EPSDT Tracking Forms must be used to document services provided and compliance with AHCCCS standards (see Appendix B). The tracking forms must be signed by the clinician who performs the screening.

EPSDT providers must adhere to the following specific standards and requirements:

1. **Immunizations** - EPSDT covers all child and adolescent immunizations as specified in the AHCCCS EPSDT Periodicity Schedule. All appropriate immunizations must be provided to bring, and maintain, each EPSDT member's immunization status up-to-date.

   Effective 12/01/2006, AHCCCS will cover the human papilloma virus (HPV) vaccine for female EPSDT members per the Advisory Committee on Immunization Practices recommended schedule.

Providers must coordinate with the Arizona Department of Health Services Vaccines for Children (VFC) program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule included in Exhibit 430-2. Contractors must ensure providers enroll and re-enroll annually with the VFC program in accordance with AHCCCS Contract requirements. The Contractor shall not utilize AHCCCS funding to purchase VFC vaccines for members under the age of 19.

Contractors must ensure providers document each EPSDT member's immunization in the Arizona State Immunization Information System (ASIIS) and maintain the ASIIS immunization records of each EPSDT member in ASIIS in accordance with A.R.S. Title 36, Section 135.

2. **Eye Examinations and Prescriptive Lenses** - EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.

3. **Blood Lead Screening** - EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test result equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or fingerstick must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children ages 6 months through 72 months (6 years) to assist in determining risk. Contractors must ensure that providers report blood lead levels equal to or greater than 10 micrograms or lead per deciliter of whole blood to the Arizona Department of Health Services (A.A.C. R9-4-302).

Contractors must implement protocols for:

a. Care coordination for members with elevated blood lead levels (parents, PCP and ADHS) to ensure timely follow-up and retesting, and

b. Transitioning a child who has an elevated blood lead level to or from another AHCCCS Contractor.

Refer to Chapter 500 for more information related to transitioning members.

4. **Organ and tissue transplantation services** - EPSDT covers medically necessary solid organ and tissue transplants approved for reimbursement in accordance with respective transplant policies, as noted in Chapter 300 of this manual. Covered transplants must not be experimental or provided primarily for the purpose of research.

   Refer to Chapter 300 (Policy 310 with Attachments A and B) in this Manual for a discussion of AHCCCS-covered transplantations.

5. **Nutritional Assessment and Nutritional Therapy**

   Nutritional Assessments: Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutrition intervention. AHCCCS covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member's PCP. AHCCCS also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP.

To initiate the referral for a nutritional assessment, the PCP must use the Contractor referral form in accordance with Contractor protocols. Prior authorization (PA) is not required when the assessment is ordered by the PCP.

If an AHCCCS covered member qualifies for nutritional therapy due to a medical condition as described in this section, then AHCCCS Contractors are the primary payor for WIC-eligible exempt infant formulas and medical foods.

If an AHCCCS covered member has one of the four congenital metabolic disorders of phenylketonuria, homocystinuria, maple syrup urine disease or galactosemia, refer to Chapter 300, Policy 320.

Nutritional Therapy: AHCCCS covers nutritional therapy for EPSDT-eligible members on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

a. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube. Refer to the specific AHCCCS Contractor for managed care members, and the AHCCCS PA Unit for Fee-for-Service members regarding PA requirements.

b. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength. Refer to the specific AHCCCS Contractor for managed care members, and the AHCCCS Prior Authorization Unit for Fee-for-Service members regarding PA requirements.

c. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

(1) PA is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. PA is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

(2) Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least the criteria specified in this policy. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or attending physician must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" (Exhibit 430-3) to obtain PA from the Contractor.

(3) The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

d. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:

(1) The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more

(2) The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent)

(3) The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)

(4) The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources

(5) Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out, or

(6) The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post-hospitalization. (PA is not required for the first 30 days.)

Contractors must develop guidelines for use by the PCP in providing the following:

a. Information necessary to obtain PA for commercial oral nutritional supplements

b. Encouragement and assistance to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, and

c. Education and training, if the member's parent or guardian elects to prepare the member's food, regarding proper sanitation and temperatures to avoid contamination of foods that are blenderized or specially prepared for the member.

Contractors must implement protocols for transitioning a child (who is receiving nutritional therapy) to or from another Contractor, or another service program (i.e., Women, Infants and Children).

Refer to Chapter 500, Policy 520, for more information related to transitioning members.

6. **Oral Health Services** - As part of the physical examination, the physician, physician's assistant or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist should be made as outlined in the Acute Care contract:

Category	Recommendation for Next Dental Visit
Emergent	Within 24 hours of request
Urgent	Within three days of request
Routine	Within 45 days of request

An oral health screening must be part of an EPSDT screening conducted by a PCP, however it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral should be documented on the EPSDT form.

Note: Although the AHCCCS EPSDT Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the Contractor's provider network.

EPSDT covers the following dental services:

a. Emergency dental services including:

(1) Treatment for pain, infection, swelling and/or injury

(2) Extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth, and

(3) General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it.

(See #8 of this section regarding conscious sedation policy)

b. Preventive dental services provided as specified in the AHCCCS EPSDT Periodicity Schedule, (Exhibit 430-1) including:

(1) Diagnostic services including comprehensive and periodic examinations

All Contractors must allow two oral examinations and two oral prophylaxis and fluoride treatments per member per year (i.e., one every six months) for members through age 20 years.

(2) Radiology services which are screening in nature for diagnosis of dental abnormalities and/or pathology, including panography or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films as needed

(3) Preventive services which include:

(a) Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian

(b) Application of topical fluorides. (Use of a prophylaxis paste containing fluoride and fluoride mouth rinses are not considered separate fluoride treatments), and

(c) Dental sealants on all non-carious permanent first and second molars and second primary molars, and

(d) Space maintainers when posterior primary teeth are lost permanently

c. All therapeutic dental services will be covered when they are considered medically necessary but may be subject to PA by the Contractor, or AHCCCS Division of Fee-for-Service Management for FFS members. These services include but are not limited to:

(1) Periodontal procedures, scaling/root planing, curettage, gingivectomy, osseous surgery

(2) Crowns:

(a) Stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or esthetic coating should be used for anterior primary teeth, or

(b) Cast non-precious or semi-precious crowns for members 18 through 20 years of age on all functional permanent endodontically treated teeth, except third molars

(3) Endodontic services including pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar

(4) Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 through 20 years of age and has had endodontic treatment, and

(5) Dentures, orthodontics and orthognathic surgery when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan designed by the PCP in consultation with the dentist.

Services or items furnished solely for cosmetic purposes are excluded from AHCCCS coverage (9 A.A.C. 22, Article 2).

Refer to Chapter 800 for information related to FFS dental services and prior authorization requirements.

7. **Cochlear Implantation -** Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). AHCCCS covers medically necessary services for cochlear implantation, as described in Chapter 300, Policy 320, for EPSDT members.

   Criteria for medical necessity of cochlear implants include, but are not limited to, the following indications:

   a. Have a diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation

   b. Deafness may be prelingual/perilingual or postlingual

   c. Have an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation

   d. Demonstrate no contraindications to surgery

   e. Demonstrate age appropriate cognitive ability to use auditory clues, and

   f. The device must be used in accordance with the FDA approved labeling.

   Cochlear implantation requires PA from the Contractor Medical Director, or from the AHCCCS Chief Medical Officer or designee for FFS members.

8. **Conscious Sedation** – AHCCCS covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while remaining able to continuously maintain adequate cardiovascular and respiratory function as well as the ability to respond purposely to verbal command and/or tactile stimulation.

   Coverage is limited to the following procedures:

   a. Bone marrow biopsy with needle or trocar

b. Bone marrow aspiration

c. Intravenous chemotherapy administration, push technique

d. Chemotherapy administration into central nervous system by spinal puncture

e. Diagnostic lumbar spinal puncture, and

f. Therapeutic spinal puncture for drainage of cerebrospinal fluid.

Additional applications of conscious sedation for members receiving EPSDT services will be considered on a case by case basis and require medical review and prior authorization by the Contractor Medical Director for enrolled members or by the AHCCCS Chief Medical Officer or designee for FFS members.

9. Behavioral health services

AHCCCS covers behavioral health services for members eligible for EPSDT services as described in Chapter 300, Policy 310, and Appendix G.

10. Religious Non-Medical Health Care Institution Services

AHCCCS covers religious non-medical health care institution services for members eligible for EPSDT services as described in Chapter 300, Policy 310.

11. Case Management Services

AHCCCS covers case management services as appropriate for members eligible for EPSDT services.

12. Chiropractic Services

AHCCCS covers chiropractic services to members eligible for EPSDT services when prescribed by the member's PCP and approved by the Contractor in order to ameliorate the member's medical condition.

13. Personal Care Services

AHCCCS covers personal care services, as appropriate, for members eligible for EPSDT services.

14. Incontinence Briefs

Incontinence briefs, including pull-ups, are covered for EPSDT members who are three (3) years or older and under age twenty-one (21) who have a documented disability, in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities. The benefit is limited to 240 briefs per month, except as described in b(2) below.

Minimum documentation requirements for coverage include:

a. Current documentation of a disability that causes incontinence of bowel and/or bladder, and

b. A prescription from the PCP or attending physician ordering incontinence briefs. Additional documentation may be required for the following circumstances:

   1) Specialty briefs – A physician prescription supporting medical necessity may be required for specialty briefs (for instance, hypo-allergenic briefs) or for briefs different from the standard briefs supplied by the Contractor.

   2) Greater than 240 briefs per month – A physician prescription supporting medical necessity may be required for members who require greater than 240 briefs per month due to a diagnosis of chronic diarrhea and/or spastic colon.

Contractors and AHCCCSA may impose reasonable prior authorization and network requirements. AHCCCS Contractors may require a new prior authorization to be issued every twelve (12) months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member, rather than an in-person physician visit.

D. CONTRACTOR REQUIREMENTS FOR PROVIDING EPSDT SERVICES

This section provides the procedural requirements for Contractors. Contractors must:

1. Have appropriately qualified personnel in sufficient numbers to meet the health care needs of members and fulfill Federal and State EPSDT requirements

2. Inform all participating primary care providers (PCPs) about EPSDT requirements.

   This must include informing PCPs of Federal, State and AHCCCS policy requirements for EPSDT and updates of new information as it becomes available, including the 01/01/2006 implementation of the Parental Evaluation of Developmental Screening (PEDS) tool for developmental screening by trained PCPs when EPSDT-age members were admitted to the NICU following birth.

   If providing care to NICU-discharged EPSDT members, PCPs should:

   a. Attend a PEDS training session.

   b. Submit proof of participation in a PEDS training session to the AHCCCS Provider Registration Unit for inclusion in the PCP's profile.

   The PCP will obtain additional reimbursement for use of the PEDS tool during EPSDT visits for NICU-discharged EPSDT members only when there is proof of training with the PEDS tool in his/her AHCCCS Provider Registration profile.

3. Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with the Contractor. This information must include:

   a. The benefits of preventive health care

   b. A complete description of the services available

   c. Information on how to obtain these services and assistance with scheduling appointments

   d. A statement that there is no co-payment or other charge for EPSDT screening and resultant services, and

e. A statement that assistance with medically necessary transportation is available to obtain EPSDT services.

4. Provide EPSDT information, defined in #3 above, in a second language, in addition to English, in accordance with the requirements of the AHCCCS Division of Health Care Management (DHCM) "Cultural Competency" policy available in the AHCCCS Contractor Operations Manual (available on the AHCCCS Web site at www.ahcccs.state.az.us)

5. Develop, implement and maintain a procedure to notify all members/caretakers prior to visits required by the AHCCCS EPSDT Periodicity Schedule. This procedure must include:

   a. Notification of members or responsible parties regarding due dates of each periodic screen. If there has been no response to scheduling, a second written notice must be sent.

   b. Notification of members or responsible parties regarding due date of an annual dental visit. If there has been no response to scheduling, a second notice must be sent.

   NOTE: Contractors should encourage all providers to schedule the next periodic screen at the current office visit, particularly for children 24 months of age and younger.

6. Distribute and require the use of the AHCCCS EPSDT Periodicity Schedule and AHCCCS approved, standardized EPSDT Tracking Forms (see Appendix B) by all contracted providers. The AHCCCS EPSDT Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and visits must be rendered by providers.

7. The AHCCCS EPSDT Tracking Forms and PEDS tool (as appropriate) are to be used by providers to document all age specific, required information related to the EPSDT screenings and visits. Copies of the EPSDT Tracking Form and PEDS tool (as appropriate), signed by the provider, must be placed in the member's medical record. If the member is enrolled with a Contractor, copies of the EPSDT Tracking Form and PEDS tool (as appropriate) must be sent to that Contractor. If the member is fee-for-service, the provider should maintain a copy of the EPSDT Tracking Form and PEDS tool (as appropriate) in the medical record, but does not need to send copies elsewhere.

AHCCCS does not require submission of EPSDT Tracking Forms or PEDS tool copies to its office.

7. Submit to AHCCCS DHCM, within 15 days of the end of each month, copies of the PEDS tools and copies of the PEDS provider survey form received during the previous month.

8. Submit to AHCCCS DHCM, within 15 days of the end of each reporting quarter, a detailed progress report that describes the activities of the quarter and the progress made in reaching the established goals of the plan. (See Exhibit 400-1.) Quarterly reports must include documentation of monitoring, evaluation and implementation of improvement processes related to:

   a. AHCCCS performance measures

   b. Blood lead screening

   c. Tuberculosis screening

   d. Provider compliance with VFC and ASIIS, and

   e. Member and provider outreach.

   The quarterly report should include results of Contractor's ongoing monitoring of performance rates for each of the items listed above in a format that will facilitate comparison of rates in order to identify possible need for interventions to improve or sustain rates. The report should also identify the Contractor's established goals.

9. Have a written EPSDT plan including oral health, which addresses the objectives, monitoring and evaluation activities of their program.

10. Participate in an annual review of EPSDT requirements conducted by AHCCCS Administration, including on-site visits to providers and medical record audits

11. Include language in PCP contracts that requires PCPs to:

    a. Provide EPSDT services for all assigned members from birth through 20 years of age. Services must be provided in accordance with the AHCCCS EPSDT Periodicity Schedule, and

    b. Agree to utilize the standardized AHCCCS EPSDT Tracking Forms

12. Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements

13. Ensure that members younger than five years old are referred for support services, including the Women, Infants and Children Supplemental Nutrition Programs, as well as other community-based resources to support good health outcomes

14. Coordinate with Head Start to ensure optimum child health and development

15. Coordinate with the Arizona Early Intervention Program (AzEIP) to identify children ages 0-3 years having developmental disabilities for services including family education and family support needs with a focus on natural environment to ensure optimum child health development. (EPSDT services, as defined in 9 A.A.C. 22, Article 2, must be provided by the Contractors.) Contractors must educate their providers on the Contractor's requirements for accessing AzEIP services. Contractors must encourage their providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member's AzEIP enrollment.

16. Coordinate with behavioral health services agencies and providers to ensure continuity of care for members who are receiving or are eligible to receive behavioral health services.

E. CONTRACTOR REQUIREMENTS FOR THE WRITTEN EPSDT PLAN

The written EPSDT plan must contain the following:

1. A narrative description of all planned activities to address Contractor's minimum requirements for the EPSDT program. Contractors should attach relevant policies and procedures to this section.

2. A work plan containing:

   a. Specific measurable objectives. These objectives may be based on AHCCCS established minimum performance standards or other generally accepted benchmarks. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks may be used (e.g., National Committee on Quality Assurance, Healthy People 2010 standards).

   b. Strategies and activities to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the maternity care services program)

   c. Targeted implementation and completion dates of work plan activities

   d. Monitoring of work plan activities and evaluation of outcomes, and

   e. Contractor assigned resources for EPSDT activities.

3. The plan must be submitted annually to AHCCCS/Division of Health Care Management as per the contract and is subject to approval. (See Exhibit 400-1.)

F. FEE-FOR-SERVICE/EPSDT PROVIDER REQUIREMENTS

This section discusses the procedural requirements for FFS EPSDT service providers. FFS providers must:

1. Provide EPSDT services in accordance with Section 1905 (R) of the Social Security Act, 42 CFR 441, Subpart B, and 9 A.A.C. 22, Article 2

2. Provide and document EPSDT screening services in accordance with the AHCCCS EPSDT Periodicity Schedule

3. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services

4. If appropriate, document in the medical record the member's or legal guardian's decision not to utilize EPSDT services or receive immunizations

5. Document a health database assessment on each EPSDT participant. The database must be interpreted by a physician or licensed health professional who is under the supervision of a physician, and

6. Provide health counseling/education at initial and follow up visits.

EXHIBIT 430-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE

EXHIBIT 430-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE

PROCEDURES	INFANCY								EARLY CHILDHOOD					MIDDLE CHILDHOOD			ADOLESCENCE
	new born	2-4 day	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	Yearly - age 10 up to age 21
History Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Height & Weight	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Head Circumference	x	x	x	x	x	x	x	x	x	x	x						
Blood Pressure												x	x	x	x	x	x
Nutritional Assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vision	SEE SEPARATE SCHEDULE																
Hearing/Speech	SEE SEPARATE SCHEDULE																
Dev./Behavioral Assess.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Examination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Immunization	← x →			x	x	x		← x →					← x →				← →
Tuberculin Test								+	+	+	+	+	+	+	+	+	+
Hematocrit/Hemoglobin			← →				x										← 14 →
Urinalysis														x			← 14 →
Lead Screen																	
Verbal						x	x		x	x		x	x	x	x		
Blood								x			x	x*	x*	x*	x*		
Anticipatory Guidance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Dental Referral	SEE SEPARATE SCHEDULE																

These are minimum requirements. If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Key: x = to be completed + = to be performed for members at risk when indicated.

← x → = the range during which a service may be provided, with the x indicating the preferred age.

* Members not previously screened who fall within this range (36 to 72 months of age) must have a blood lead screen performed.

NOTE: If American Academy of Pediatrics guidelines are used for the screening schedule and/or more screenings are medically necessary, those additional interperiodic screenings will be covered

Revised 08/01/2005

EXHIBIT 430-1 (con't)

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL PERIODICITY SCHEDULE

	MONTHS	YEARS																		
PROCEDURE	Birth thru 12 months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+ up to 21
DENTAL REFERRAL	+	←		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

The American Association of Pediatric Dentistry recommends that dental visits begin by age one (1). PCP referrals for dental care are mandatory beginning at age three (3). Referrals should be encouraged by age one (1). Parents of young children may self refer to a dentist within the Contractor's network at any time.

AHCCCS covers subsequent examinations as prescribed by the dentist within the EPSDT standards.

Key: + = if indicated
x = to be completed

Revised 08-01-2005

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
VISION PERIODICITY SCHEDULE

	MONTHS											YEARS														
Procedure	New born	2 - 4 Days	by 1 mo	2	4	6	9	12	15	18	24	3*	4	5	6	8	10	11	12	13	14	15	16	17	18	19 up to 21 yrs
Vision +	S	S	S	S	S	S	S	S	S	S	S	O	O	O	S	S	O	S	O	S	S	S	S	S	O	S

<u>These are minimum requirements</u>: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key: S =Subjective, by history O = Objective, by a standard testing method
*** = If the patient is uncooperative, rescreen in 6 months.**
\+ = May be done more frequently if indicated or at increased risk.

Revised 08/01/2005

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEARING AND SPEECH PERIODICITY SCHEDULE

	MONTHS											YEARS														
Procedure	New born	2 - 4 Days	by 1 mo	2	4	6	9	12	15	18	24	3	4	5	6	8	10	11	12	13	14	15	16	17	18	19 up to 21 yr
Hearing/ Speech+	S/O	S	S	S	S	S	S	S	S	S	S	O	O	O	S	S	O	S	O	S	S	S	S	S	O	S

<u>These are minimum requirements</u>: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

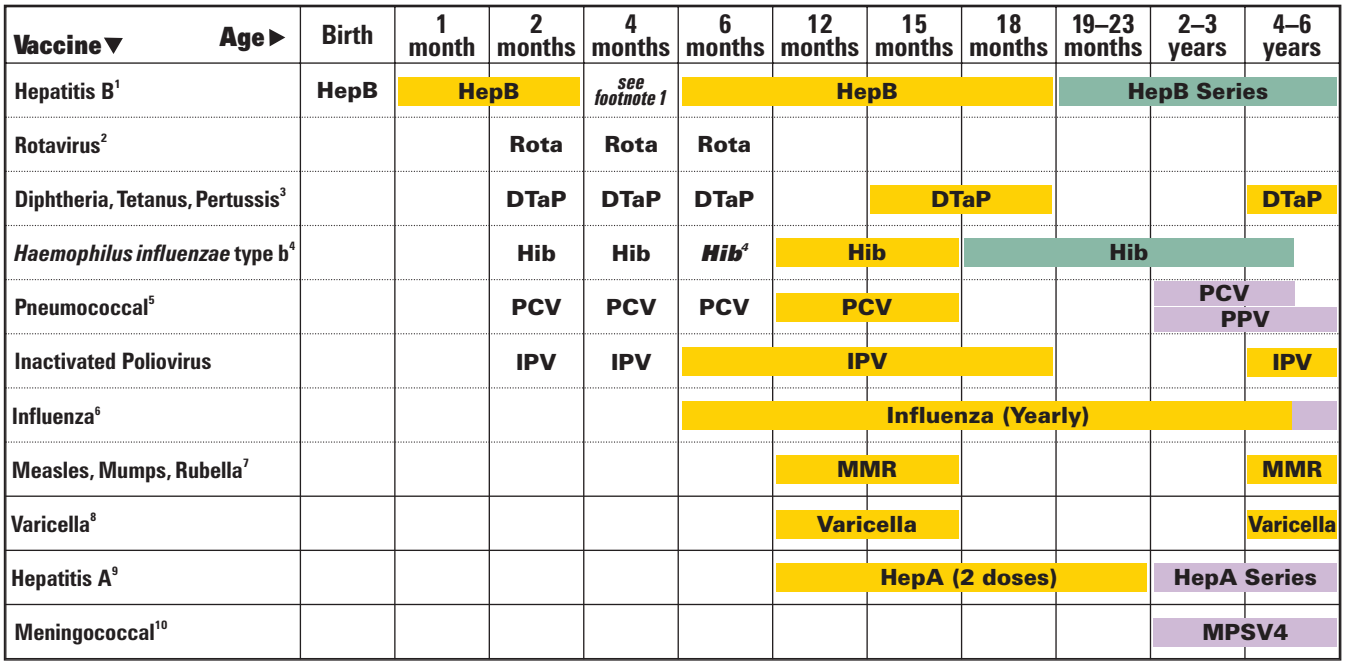
Key: S =Subjective, by history O = Objective, by a standard testing method
*** = All children, including newborns, meeting risk criteria for hearing loss should be objectively screened.**
\+ = May be done more frequently if indicated or at increased risk

Revised 08/01/2005

EXHIBIT 430-2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2007



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 0–6 years. Additional information is available at http://www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **http://www.vaers, hhs.gov** or by telephone, **800-822-7967**.

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of ≥3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*

- Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHiBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged ≥12 months.

5. Pneumococcal vaccine. *(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])*

- Administer PCV at ages 24–59 months in certain high-risk groups. Administer PPV to children aged ≥2 years in certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

6. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])*

- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. *(Minimum age: 12 months)*

- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*

- HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Meningococcal polysaccharide vaccine (MPSV4). *(Minimum age: 2 years)*

- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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CS103164

Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2007

Vaccine ▼ / Age ▶	7–10 years	11–12 YEARS	13–14 years	15 years	16–18 years
Tetanus, Diphtheria, Pertussis[1]	see footnote 1	Tdap	Tdap		
Human Papillomavirus[2]	see footnote 2	HPV (3 doses)	HPV Series		
Meningococcal[3]	MPSV4	MCV4	MCV4	MCV4[3]	
Pneumococcal[4]	PPV				
Influenza[5]	Influenza (Yearly)				
Hepatitis A[6]	HepA Series				
Hepatitis B[7]	HepB Series				
Inactivated Poliovirus[8]	IPV Series				
Measles, Mumps, Rubella[9]	MMR Series				
Varicella[10]	Varicella Series				

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at http://www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).
(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)
- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

2. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. *(Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])*
- Administer MCV4 at age 11–12 years and to previously unvaccinated adolescents at high school entry (at approximately age 15 years).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). *(Minimum age: 2 years)*
- Administer for certain high-risk groups. See *MMWR* 1997;46(No. RR-8):1–24, and *MMWR* 2000;49(No. RR-9):1–35.

5. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])*
- Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55 (No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*
- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55 (No. RR-7):1–23.

7. Hepatitis B vaccine (HepB). *(Minimum age: birth)*
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). *(Minimum age: 6 weeks)*
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*
- If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥4 weeks between the doses.

10. Varicella vaccine. *(Minimum age: 12 months)*
- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged <13 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days after the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥13 years at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

CS100131

Catch-up Immunization Schedule for Persons Aged 4 Months–18 Years Who Start Late or Who Are More Than 1 Month Behind

UNITED STATES • 2007

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS–6 YEARS					
Hepatitis B[1]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Rotavirus[2]	6 wks	4 weeks	4 weeks		
Diphtheria, Tetanus, Pertussis[3]	6 wks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 wks	4 weeks if first dose administered at age <12 months 8 weeks (as final dose) if first dose administered at age 12-14 months No further doses needed if first dose administered at age ≥15 months	4 weeks[4] if current age <12 months 8 weeks (as final dose)[4] if current age ≥12 months and second dose administered at age <15 months No further doses needed if previous dose administered at age ≥15 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[5]	6 wks	4 weeks if first dose administered at age <12 months and current age <24 months 8 weeks (as final dose) if first dose administered at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose administered at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose administered at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	4 weeks[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	3 months			
Hepatitis A[9]	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7–18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	7 yrs[10]	4 weeks	8 weeks if first dose administered at age <12 months 6 months if first dose administered at age ≥12 months	6 months if first dose administered at age <12 months	
Human Papillomavirus[11]	9 yrs	4 weeks	12 weeks		
Hepatitis A[9]	12 mos	6 months			
Hepatitis B[1]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	4 weeks[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	4 weeks if first dose administered at age ≥13 years 3 months if first dose administered at age <13 years			

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*
- Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*
- The fifth dose is not necessary if the fourth dose was administered at age ≥4 years.
- DTaP is not indicated for persons aged ≥7 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*
- Vaccine is not generally recommended for children aged ≥5 years.
- If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12– 15 months and at least 8 weeks after the second dose.
- If first dose was administered at age 7–11 months, administer 2 doses separated by 4 weeks plus a booster at age 12–15 months.

5. Pneumococcal conjugate vaccine (PCV). *(Minimum age: 6 weeks)*
- Vaccine is not generally recommended for children aged ≥5 years.

6. Inactivated poliovirus vaccine (IPV). *(Minimum age: 6 weeks)*
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*
- The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
- If not previously vaccinated, administer 2 doses of MMR during any visit with ≥4 weeks between the doses.

8. Varicella vaccine. *(Minimum age: 12 months)*
- The second dose of varicella vaccine is recommended routinely at age 4–6 years but may be administered earlier if desired.
- Do not repeat the second dose in persons aged <13 years if administered ≥28 days after the first dose.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*
- HepA is recommended for certain groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). *(Minimum ages: 7 years for Td, 10 years for BOOSTRIX®, and 11 years for ADACEL™)*
- Tdap should be substituted for a single dose of Td in the primary catch-up series or as a booster if age appropriate; use Td for other doses.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. A booster (fourth) dose is needed if any of the previous doses were administered at age <12 months. Refer to ACIP recommendations for further information. See *MMWR* 2006;55(No. RR-3).

11. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

Information about reporting reactions after immunization is available online at **http://www.vaers.hhs.gov** or by telephone via the 24-hour national toll-free information line 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at **http://www.cdc.gov/nip/default.htm** or telephone, **800-CDC-INFO (800-232-4636)**.

CS103164

EXHIBIT 430-3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT MEMBERS)

EXHIBIT 430-3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT MEMBERS)

SUBMITTED BY:

Provider Name: _____

Provider AHCCCS ID Number: _____ Telephone: _____

MEMBER INFORMATION

Member's Name: _____ Date of Birth: _____
Last First Initial

Member's AHCCCS ID Number: _____ Enrollment: _____
(Contractor)

Member's Address: _____

_____

ASSESSMENT FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

Assessment performed by: _____

AHCCCS Provider ID: _____ Telephone Number: _____

Date of Assessment: _____

Assessment Findings: (If necessary, add attachments to provide the most complete information)

1. Indicate which of the following criteria have been met to determine that oral supplemental nutritional feedings are medically necessary. (At least two of the following must be met.) Check all that apply.

a. The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for 3 months or more.	
b. The member has reached a plateau in growth and/or nutritional status for more than 6 months (prepubescent).	
c. The member has already demonstrated a medically significant decline in weight within the past 3 months (prior to the assessment).	
d. The member is able to consume/eat no more than 25% of his/her nutritional requirements from normal food sources.	
e. Absorption problems are evidenced by emesis, diarrhea, dehydration, weight loss, and intolerance to milk or formula products has been ruled out.	
f. The member requires oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. post-hospitalization. (No PA for first 30 days)	

2. List past nutritional counseling efforts and alternative nutritional feedings which were tried (include by whom and the length of time that counseling was conducted and/or the alternative feedings that were used.)

ORAL SUPPLEMENTAL NUTRITIONAL FEEDING RECOMMENDATIONS

Type of Nutritional Feeding	**Source of Nutrition**
Weaning from Tube Feeding	
Oral Feeding - Sole Source (PA required)	
Oral Feeding - Supplemental (PA Required)	
Emergency Supplemental Nutrition (No PA required for first 30 days)	

Additional Comments:

_____ _____

Nutritional Assessment Provider Date Member's PCP/Attending Physician Date

440 KIDSCARE SERVICES

This Policy provides information about the health care services available under the Federal Children's Health Insurance Program (Title XXI), known as the Arizona KidsCare Program. The KidsCare Program is administered by AHCCCS and provides health care coverage statewide to eligible children under age 19. Covered services are provided through AHCCCS Contractors. In addition, AHCCCS enters into Intergovernmental Agreements with Indian Health Service and 638 Tribal Facilities for services to be provided to Native American members who select these programs for primary care.

Parents of KidsCare children qualify under the Health Insurance Flexibility and Accountability Act (HIFA). HIFA members are entitled to receive AHCCCS benefits as discussed in Chapter 300 of this Manual.

A. COVERED SERVICES

The KidsCare Program offers comprehensive medical, preventive and treatment services, and a full array of behavioral health care pursuant to Arizona Revised Statutes Title 36, Chapter 29, Article 4. All covered services must be medically necessary and provided by a primary care provider or other AHCCCS registered providers who meet qualifications as described in Chapter 600 of this Manual.

KidsCare services must be provided according to community standards and standards set forth for members enrolled under Title XIX for Early and Periodic Screening, Diagnosis and Treatment services. Service descriptions and limitations included in Chapter 300 and Chapter 400 of this Manual will also apply for the KidsCare Program.

Some services provided to KidsCare members will require prior authorization (PA), either from the Contractor with whom the member is enrolled, or from AHCCCS Division of Fee for Service Management (DFSM) for members who are receiving services on a fee for service basis.

Refer to Chapter 800, Policy 810, for procedures/methodologies to request PA and requirements related to concurrent review.

Refer to Arizona Administrative Code, Title 9, Chapter 34 (9 A.A.C. 34) for notice of action requirements if a service requiring PA is denied, reduced, suspended or terminated by either a Contractor or AHCCCS Administration

B. EXCLUDED SERVICES UNDER THE KIDSCARE PROGRAM

Licensed midwife services for prenatal care and home births are excluded from coverage under the KidsCare program, in accordance with A.A.C. R9-31-215.

Additionally, persons residing in an Institution for Mental Disease at the time of initial eligibility determination or subsequent redetermination are not eligible for KidsCare.

Refer to Chapter 800, Policy 810, for procedures/methodologies to request PA and requirements related to concurrent review.

C. CARE COORDINATION RESPONSIBILITIES

Contractors must follow policies set forth in Chapter 500 of this Manual.

D. MONITORING AND ASSESSING THE QUALITY OF CARE RECEIVED BY KIDSCARE MEMBERS

Contractors must comply with all Quality Management and Performance Improvement requirements specified in Chapter 900 of this manual. In addition, Contractors must comply with utilization management requirements included in Chapter 1000. Acute care Contractors are encouraged to include in their annual Early and Periodic Screening, Diagnosis and Treatment (EPSDT) plans and quarterly progress reports activities that will increase utilization of services by KidsCare members and/or acknowledge that EPSDT activities and objectives apply to both Title XIX members and those covered under Title XXI.

Contractors for Acute Care are encouraged to implement prior authorization (PA) and utilization management for the KidsCare Program services whenever appropriate. Specific Contractor PA requirements are not identified in this manual. To obtain details regarding these PA requirements for specific services, please contact the appropriate Contractor.

E. SERVICE DELIVERY REQUIREMENTS FOR INDIAN HEALTH SERVICE (IHS) AND 638 TRIBAL FACILITIES

For their primary health care provider, KidsCare members who are Native American may elect to enroll with an AHCCCS Contractor, IHS, or a 638 Tribal Facility. Behavioral health services not provided by IHS or a 638 Tribal Facility may be provided by a Regional Behavioral Health Authority (RBHA) or a Tribal RBHA (TRBHA).

If IHS or a 638 Facility is selected, the member must obtain services specified in this Chapter from IHS or the 638 Tribal Facility whenever possible. Upon referral by IHS or the 638 Tribal Facility, covered services not available through IHS or the 638 Tribal Facility can be provided by AHCCCS fee-for-service (FFS) providers and reimbursed through AHCCCS Administration. Prior to or at the time services are rendered, a referral form must be supplied to the AHCCCS FFS provider and the FFS provider must obtain prior authorization (PA) from AHCCCS/Division of Fee for Service Management. (PA is not required for emergency transportation or medical, dental or behavioral health services provided on an emergency basis.) The procedures to obtain IHS referral and AHCCCS PA are addressed in Chapter 800, Policies 810 and 850. The benefit and coverage conditions for each service are addressed in Chapter 300 and Chapter 400 of this Manual.

IHS and 638 Tribal Facilities must ensure that providers who render services under the KidsCare Program are registered with AHCCCS. Each member should be assigned to an IHS or 638 Tribal Facility provider who is responsible for providing, coordinating, and/or supervising medical services rendered to assigned members. This includes maintaining continuity of care and maintaining a complete individual medical record for each assigned member that is in compliance with requirements of Chapter 900, Policy 940, of this Manual. They are also responsible for providing necessary referrals for specialty care.

450 CHILDREN'S REHABILITATIVE SERVICES

Definitions

The words and phrases in this policy have the following meanings, unless the context explicitly requires another meaning:

AHCCCS Contractor: Acute Care and ALTCS Contractors, the Department of Economic Security (DES)-Division of Developmental Disabilities, and the DES Comprehensive Medical Dental Program.

Appointment standards: standards for arranging appointments for medically necessary CRS services as defined in CRS/AHCCCS Contract.

CRS contractor: regional subcontractor responsible for arranging covered services for CRS recipients as defined in CRS/AHCCCS Contract.

CRS recipient: child eligible for the CRS program under Arizona Administrative Code Title 9, Chapter 7.

Timely appointment: an appointment timeframe that, if not met, may adversely affect the health of an enrolled member.

A. MEDICALLY NECESSARY APPOINTMENT POLICY

Children's Rehabilitative Services Administration (CRSA) is responsible for having procedures in place to ensure that appointment standards are met and to monitor the Children's Rehabilitative Services (CRS) contractors' compliance with appointment standards. CRSA has established a mechanism for CRS contractors to notify CRSA when they are unable to meet appointment standards.

This policy establishes the procedures for AHCCCS Contractors to obtain reimbursement for providing CRS covered services to AHCCCS/CRS enrolled members when a CRS contractor is unable to arrange for timely appointments for medically necessary services related to the member's CRS condition. This policy defines the AHCCCS Contractor's requirements for problem resolution, notification, service arrangement, documentation, and timeliness to be considered for reimbursement by AHCCCSA. It also includes CRSA's requirements for problem resolution and notification of the AHCCCS Contractor.

The AHCCCS Contractor remains ultimately responsible for the provision of all covered services to its members, including emergency services not related to a CRS condition, emergency services related to a CRS condition rendered outside the CRS network, and AHCCCS covered services denied by CRSA for the reason that it is not a service related to a CRS condition.

B. CARE COORDINATION REQUIREMENTS

The AHCCCS Contractor is responsible for care of members until those members are determined eligible by CRSA. In addition, the Contractor is responsible for covered services for CRS eligible members unless and until the Contractor has received written confirmation from CRSA that CRSA will provide the requested service.

If a Children's Rehabilitative Services (CRS) contractor is not able to provide timely appointments for medically necessary services, the following procedures apply:

1. If Children's Rehabilitative Services Administration (CRSA) is aware that a CRS contractor is unable to provide timely appointments for medically necessary services, CRSA is responsible for notifying a member's AHCCCS Contractor.

2. If an AHCCCS Contractor is notified by a primary care provider, a member, or member's representative that a CRS contractor is unable to provide timely appointments for medically necessary services, the AHCCCS Contractor must contact the CRS contractor to attempt to resolve the issue. If unable to resolve the issue, the AHCCCS Contractor Medical Director must contact the CRSA Medical Director to discuss the member's medical necessity for a timely appointment.

3. If the CRSA Medical Director is unable to resolve the issue and the CRS contractor cannot provide a timely appointment for medically necessary services, the AHCCCS Contractor must:

   a. Notify the AHCCCS Division of Health Care Management, Manager of Operations

   b. Arrange for the CRS recipient to receive the services, and

   c. Reimburse the provider for the services.

4. Referral to CRSA does not relieve the Contractor of the responsibility for timely provision of medically necessary AHCCCS services not covered by CRSA. In the event that CRSA denies a medically necessary AHCCCS service for the reason that it is not related to a CRS condition, the Contractor must promptly respond to the service authorization request and authorize the provision of medically necessary services. Refer to AHCCCS Contract for discussion of resolution on disputes between AHCCCS Contractors and CRSA related to CRS covered services.

   Refer to Chapter 500 for additional care coordination requirements.

   Refer to the AHCCCS Contractor Operations Manual, "Notice of Action" policy, for notification requirements. This manual is available from the AHCCCS Web site at www.ahcccs.state.az.us.

C. ADMINISTRATIVE REQUIREMENTS

1. The AHCCCS Contractor that is required to pay the claim must prepare a detailed statement of the costs incurred, including at a minimum:

   a. Documentation of the conversation between the Medical Directors of the AHCCCS Contractor and CRSA

b. Date the member was identified as a CRS recipient

c. Diagnosis

d. Date services requested

e. Date services provided

f. Description of services provided

g. Billed charges and payment amount

h. Invoices for services including claim and explanation of benefits or remittance advice, and

i. Documentation of the medical necessity of the timely appointment and that the services were related to a CRS covered condition.

2. If the provider of the services is capitated by the AHCCCS Contractor, the AHCCCS fee-for-service rates are to be used to value the service(s) for purposes of recoupment or recovery of those monies from CRSA.

3. Within 60 days of payment to the provider, the AHCCCS Contractor must submit copies of the detailed statement of costs to:

AHCCCS
Division of Health Care Management
Manager of Operations
701 E. Jefferson St., Mail Drop 6100
Phoenix AZ 85034

4. AHCCCS/Division of Health Care Management will review the statements to confirm the medical necessity of the service. AHCCCSA will contact CRSA to receive additional information and discuss rationale for the service and will render a determination within fifteen days, and forward those claims to the AHCCCS Division of Business and Finance (DBF) within five days of the determination.

5. DBF must reimburse the AHCCCS Contractor within 30 days of receipt of the determination of medical necessity from AHCCCS/DHCM.

6. AHCCCS/DBF will reimburse the Contractor for the amount paid to the provider with funds recouped/withheld from CRSA.

D. MONITORING AND ASSESSING THE TIMELINESS OF MEDICALLY NECESSARY APPOINTMENTS FOR CHILDREN'S REHABILITATIVE SERVICE RECIPIENTS

AHCCCS/Division of Health Care Management will track cases submitted for determination of medical necessity, identify trends, and request corrective action or other remedies defined in contract if timely appointments for medically necessary services are not being provided.

The Acute Care/ALTCS Contractor is responsible for the timeframes outlined in the AHCCCS "Notice of Action" policy when a request for services is received from a provider for a child who is, or may be, eligible to receive the services through CRS. This policy is available in the AHCCCS Contractor Operations Manual, available on the AHCCCS Web site at www.ahcccs.state.az.us.

The Acute Care/ALTCS Contractor will assist the member to contact CRS as necessary. If the member is not enrolled with CRS, but may have a CRS eligible condition, the Contractor will:

1. Contact the member's parent/legal guardian and assist them in completing a CRS application

2. Request appropriate clinical documentation from the member's provider(s), and

3. Fax the application and clinical notes to the appropriate CRS office.

The Acute Care/ALTCS Contractor will monitor:

1. The status of the CRS application to ensure the member is seen within the approved timeframes

2. The date of the intake appointment, and

3. The date of the first appointment with a specialist.

Contractors must implement protocols for transitioning a child who will be turning 21 years old in six months from CRS services back into the Contractor's network system.

Refer to AHCCCS Acute Care, ALTCS and CRS Contracts for additional requirements and further clarification.